REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Inquest into the death of Clive GOULD

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, South Central Ambulance Service**
1	**CORONER** I am Nicholas Graham, Assistant Coroner, for the Coroner area of Oxfordshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION AND INQUEST** On 22 July 2013 an investigation commenced into the death of Clive Gould, who was 76 years old. The investigation concluded at the end of the inquest on 11 December 2013. The narrative conclusion of the inquest was that Mr Gould died on the morning of 18 July 2013 and that an ambulance was called at 4:18am but did not arrive until 5:47am, the medical cause of death being Congestive Cardiac Failure.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Gould had a complex past medical history of small cell lung cancer, pulmonary embolism, vasculitis, interstitial lung disease, emphysema, atrial fibrillation, hypertension, left ventricular dysfunction and previous bladder cancer. 2. He was receiving chemotherapy for his lung cancer and had last received treatment on 17 July 2013. 3. During the early hours of 18 July he awoke complaining of sickness and shortness of breath and his wife rang the ambulance at 4:18am. Despite five follow up calls the ambulance did not arrive until 5:47am. 4. Sadly, Mr Gould had gone into cardiac arrest by the time the ambulance arrived and could not be revived. 5. At 6:22am death was confirmed.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The original call made by [redacted] was allocated a priority green status which meant that should a higher priority call be received (a red status call) then an ambulance would be diverted, which is what happened on two occasions. An internal audit of that call suggests that a different priority could have been given to

	the original call and the presenting concerns of Mr Gould's status. I recommend that SCAS review how they allocate priority to calls such as this one and identify whether any improvements to the allocation of priority should be given. (2) In evidence before the inquest SCAS indicated that there was little resilience in the system to tolerate absence or sudden sickness of personnel at certain times. My recommendation is that SCAS look at the resilience, particularly in rural areas, to consider whether further resources may need to be deployed. (3) The evidence from the family at the inquest was that they were informed that an ambulance would be arriving shortly. Had they known that there was to be the delays that occurred because other calls had been given priority, they informed me that they could have used first aid resources available to them within the village, such as locally trained first aiders etc. My recommendation is that SCAS review what information they give callers and to consider whether communication in relation to estimated times of arrival should be notified to callers or the possibility of delays.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. My recommendations in respect of reviews to be carried out are set out above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 10 February 2013. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and to [redacted] one of the Interested Persons. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 16 December 2013** ..... **Nicholas Graham, Deputy Coroner**